Appendix K: Completing Claim Form 2006 ADA Claim Form

The following instructions explain how to complete the 2006 ADA claim form. Be sure the information printed on the claim form is centered in the fields so that it is readable by the Agency scanner system. Do not handwrite the claim and use highlighters or markers on the claim.

Note: The Agency is not currently accepting the new 2012 ADA claim form.

Field	Name	Action
2	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field.
3	Company/Plan Name, Address, City, State, Zip Code	Enter the claims address for the Health Care Authority.
4	Other Dental or Medical Coverage	Check the appropriate box.
5	Name of Policyholder/Subscriber (Last, First, Middle Initial, Suffix)	If different from the patient, enter the name of the subscriber.
6	Date of Birth	Enter the subscriber's date of birth. Hyphens, dashes, etc. are not needed.
8	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the subscriber's SSN or other identifier assigned by the payer.
9	Plan/Group Number	If the client has third party coverage, enter the dental plan number of the subscriber.
10	Relationship to Primary Policyholder/Subscriber	Check the applicable box.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter any other applicable third party insurance.
12	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility.  **Note:** be sure to insert commas separating sections of the name!
13	Date of Birth (MMDDCCYY)	Enter the client's date of birth. Hyphens, dashes, etc. are not needed.
14	Gender	Check the applicable box.
15	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the patient's ProviderOne Client ID (123456789WA)
16	Plan/Group Number	Enter the subscriber's group Plan or Policy Number.
18	Relationship to Policyholder/Subscriber	Check the appropriate box.
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility.  **Note:** This field is not required if "self" is checked in box 18.

Field	Name	Action
21	Date of Birth (MMDDCCYY)	Enter the client's date of birth. Hyphens, dashes, etc. are not needed.  **Note:** This field is not required if "self" is checked in box 18.
22	Gender	Check the appropriate box.  **Note:** This field is not required if "self" is checked in box 18.
23	Patient ID/Account #	Not required (optional field for your internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. This number will be printed on the Remittance and Status Report (RA) under the heading Patient Account Number.
24	Procedure Date (MMDDCCYY)	Enter the eight-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 04012007). Hyphens, dashes, etc. are not needed.
25	Area of Oral Cavity	If the procedure code requires an arch or a quadrant designation, enter one of the following: 01 Maxillary area 02 Mandibular area 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number, letter(s): 1. 1 through 32 for permanent teeth 2. A through T for primary teeth 3. 51 through 82 or AS through TS for supernumerary teeth **4. Only one tooth number may be billed per line** Do not fill in preceding zeros for tooth numbers (e.g. tooth 1)
28	Tooth Surface	Enter the appropriate letter from the list below to indicate the tooth surface. Up to five surfaces may be listed in this column (Please separate with a comma): B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal **Note:** Make entries in this field only if the procedure requires a tooth surface.

Field	Name	Action
29	Procedure Code	Enter the appropriate current CDT procedure code that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment. **Note**: The Agency only covers procedure codes listed on our fee schedule that has a dollar amount indicated.
30	Description	Give a brief written description of the services rendered. When billing for general anesthesia or IV sedation, enter the actual beginning and ending time.
31	Fee	Enter your usual and customary fee (not the Agency's maximum allowable rate) for each service rendered. If fee schedule indicates to bill Acquisition Cost (AC) please bill your acquisition cost.
32	Other Fee(s)	
33	Total Fee	Enter the total charges. Do not include decimal points or dollar signs.
34	Missing Teeth Information	Place an "X" on the appropriate missing teeth.
35	Remarks	Enter appropriate comments in this field ▪ To indicate a payment by another plan, enter "insurance payment" and the amount. Attach the insurance EOB to the claim. ▪ If processing a void, enter the TCN in this field preceded by an 8. (e.g. 8-123456789012345678) ▪ If processing an adjustment or replacement enter the TCN in this field preceded by a 7. (e.g. 7-123456789012345678) ▪ If the claim is a adjustment and indicating an insurance payment use the following format – 7-123456789012345678 - $123.45 ▪ Indicate the client's Spenddown amount, enter **SCI=Y** and then the amount.

Field	Name	Action
38	Place of Treatment	The Agency defines the following places of service for paper claims when a place of treatment box is checked but no two-digit place of service is indicated: **Box checked** — **Place of Service (POS)** Office — Dental office (POS 11) Hospital — Outpatient hospital (POS 22) ECF — Skilled nursing facility (POS 31) Other — The Agency will not allow place of service "other" without a two digit place of service indicated. If the services rendered are not in one of the places of service as indicated above, then the two-digit POS **must** be indicated in field 38. The Agency considers the following places of service for dental claims (not all services are covered in all places of service) **Office** **11** dental office **Hosp** **21** inpatient hospital **22** outpatient hospital **23** hospital emergency room **ECF** **31** skilled nursing facility **32** nursing facility **54** intermediate care facility/mentally retarded **Other** **03** school-based services **12** client's residence **24** professional services in an ambulatory surgery center **50** federally qualified health center **71** state or public health clinic (department) The Agency requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Claims with inaccurate place of service designations will be denied.
39	Number of Enclosures	Check the appropriate box. Note: Do not send X-rays when billing for services.
40	Is Treatment for Orthodontics?	Check the appropriate box.
41	Date Appliance Placed (MMDDCCYY)	This field **must be completed** for orthodontic treatment.
42	Months of Treatment Remaining	If applicable, enter the months of treatment remaining.
43	Replacement of Prosthesis?	Check appropriate box. If "yes," enter the reason for replacement in field 35 (Remarks).

Field	Name	Action
44	Date Prior Placement (MMDDCCYY)	Enter the appropriate date if "yes" is check for field 43.
45	Treatment Resulting from	Check the appropriate box.
46	Date of Accident (MMDDCCYY)	If applicable, enter the date of accident.
47	Auto Accident State	Enter the two letter abbreviation for whatever state the accident was in, if applicable.
48	Name, Address, City, State, Zip Code	Enter the practice or business name and address as recorded with the Agency. If a solo practice, enter the dentist name and business address as recorded with the Agency.
49	NPI	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. Without this number the claim will be denied. The provider must be enrolled as a Medicaid provider prior to start of treatment.
50	License Number	Enter the billing dentist's license number.
51	SSN or TIN	Enter the billing dentist's SSN or TIN.
52a	Additional Provider ID	Enter the taxonomy for the billing provider. For more information on taxonomy codes, please see Appendix L.
53	Treating Dentist and Treatment Location Information	Enter the treating dentist's signature and date.
54	NPI	Enter the treating provider NPI if it is different from the billing provider NPI. The treating provider must be enrolled as a Medicaid provider prior to start of treatment.
55	License Number	Enter the treating dentist's license number.
56	Address, City, State, Zip Code	Enter the treating dentists address, city state and zip code.
56a	Provider Specialty Code	Enter in the treating provider taxonomy if an NPI was entered in box 54.
58	Additional Provider ID	This field is not used by the Agency.